

AUDIT COMMITTEE
MEETING AGENDA

February 10, 2017
1:00 P.M.

125 Worth Street,
5th Floor - Rm. 532
Board Room

CALL TO ORDER

Ms. Emily A. Youssouf

- Adoption of Minutes December 8, 2016

Ms. Emily A. Youssouf

INFORMATION ITEMS

- Audits Update
- Compliance Update

Mr. Chris A. Telano

Mr. Wayne McNulty

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: December 8, 2016

TIME: 2:00 PM

COMMITTEE MEMBERS

Emily Youssouf, Chair

Gordon J. Campbell

OTHER MEMBERS OF THE BOARD

Stanley Brezenoff, CEO, NYC H+H

STAFF ATTENDEES

Salvatore J. Russo, General Counsel, Legal Affairs

Barbara Keller, First Deputy, General Counsel, Legal Affairs

Colicia Hercules, Chief of Staff, Chairman's Office

Patricia Lockhart, Secretary to the Corporation, Chairman's Office

PV Anantharam, Senior Vice President/Corporate Chief Financial Officer

Wayne McNulty, Corporate Compliance Officer/Senior Assistant Vice President

Paul Albertson, Senior Assistant Vice President, Materials Management

Machelle Allen, Interim Chief Medical Officer, Medical & Professional Affairs

James Linhart, Deputy Corporate Comptroller

Gassenia Guilford, Assistant Vice President, Finance

Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits

Devon Wilson, Senior Director, Office of Internal Audits

Chalice Piña, Director, Office of Internal Audits

Delores, Rahman, Director, Office of Internal Audits

Steve Van Schultz, Director, Office of Internal Audits

Carlotta Duran, Assistant Director, Office of Internal Audits

Rosemarie Thomas, Assistant Director, Office of Internal Audits

Frank Zanghi, Audit Manager, Office of Internal Audits

Armel Sejour, Senior Auditor, Office of Internal Audits

Melissa Bernaudo, Senior Auditor, Office of Internal Audits

Gillian Smith, Senior Auditor, Office of Internal Audits

Barbarah Gelin, Senior Auditor, Office of Internal Audits

Erica Nairne-Hamilton, Staff Auditor, Office of Internal Audits

Jean Saint-Preux, Staff Auditor, Office of Internal Audits

Roshney Kaur, Staff Auditor, Office of Internal Audits

Miriam Yeger, Staff Auditor, Office of Internal Audits

Sandy Bhigroog, Staff Auditor, Office of Internal Audits

Jessica Fortes, Staff Auditor, Office of Internal Audits

Peter Papadopoulos, Staff Auditor, Office of Internal Audits

Conny Lizarazo, Executive Secretary, Office of Internal Audits

Mahendra Patel, Senior Director, Grants Research, Central Office

L.R. Tulloch, Senior Director, Office of Facilities Development, Central Office

Jeff Lutz, Senior Director, EITS, Central Office

Aijaz Khan, Director, Grants Research, Central Office

Michelle Lewis, Ambulatory Care Service Line, Central Office

Jay Weinman, Chief Financial Officer, NYC H + H/Bellevue
Ron Townes, Associate Director, NYC H + H/Kings County
Anthony Manwaring, Controller, Gotham/East New York
Elsa Cosme, Chief Financial Officer, NYC H + H/Gouverneur
Martin Novzen, Chief Financial Officer, NYC H + H/Lincoln
Robert Bochicchio, Senior Associate Director, NYC H + H/Lincoln
Elsa Estrada, Director, NYC H+H/Lincoln
Mutiu Agbosasa, Assistant Director, NYC H + H/Metropolitan
Jose Santiago, Controller, MetroPlus
Lilly Pham, Senior Assistant Controller, MetroPlus
Rosario Ceron, Director, MetroPlus
Steven Angelo, Assistant Director, MetroPlus
Lisa Scott-McKenzie, Deputy Executive Director, NYC H + H/Woodhull
Donna Chae, Senior Associate Director, NYC H + H/Woodhull
David Nunziato, Chief Financial Officer, NYC H + H/Woodhull

OTHER ATTENDEES

KPMG: Maria Tiso, Partner, Mike Breen, Partner; Joseph Bukzin, Senior Manager
CROTHAL: Mitch Benjamin, Director, BioMed

**DECEMBER 8, 2016
AUDIT COMMITTEE MEETING
MINUTES**

A meeting of the Audit Committee was held on Thursday, December 8, 2016. The meeting was called to order at 2:00 P.M. by Ms. Youssouf, Committee Chair. Ms. Youssouf then asked for a motion to adopt the minutes of the Audit Committee held on October 13, 2016 and the minutes for a Special Audit Committee meeting held on October 20, 2016. A motion was made and seconded with all in favor. An additional motion was made and seconded to hold an Executive Session of the Audit Committee.

Ms. Youssouf then turned the floor over to KPMG personnel and asked them to introduce themselves. Ms. Maria Tiso introduced herself as the Engagement Partner and she introduced Mike Breen, Supporting Partner; Joseph Bukzin, Senior Manager.

Ms. Tiso stated that on the first page of our presentation is our opinion to the management letter, and the opinion indicates that there are no significant deficiencies or material weaknesses in the comments in the management letter. These comments that are included in this letter are intended to include the internal controls of the organization.

The next page is the matrix of observations which we will walk you through. They include comments relating to the corporate office, comments related to the site visits, and then we also have comments related to information technology and tax, and then we will also address the comments that we had included in the prior year's comments and how they have been resolved, and then I have some industry management letter comments, which are consistent to what was included in last year's comments, so I won't spend a lot of time on that. Page three and four is the matrix. Going down the left is the facilities that have been impacted by our comments, and on the top is the category of what the comments relate to.

Ms. Tiso said that I'm going to start on page five, which talks about financial reporting. I wanted to state that we just recently found out that the Corporate Comptroller position has recently been filled by Jay Weinman. He currently is in the process of transitioning, but I just wanted to highlight that during the audit process the Corporate Comptroller position was being filled by James Linhart, the Deputy Comptroller, so not only was he performing his own job responsibilities as Deputy Comptroller, he was also filling the responsibilities of Corporate Comptroller, so he had a difficult task trying to fill both roles.

There were also key financial personnel that were in the process of retiring or retired, so there were some resource constraints during the audit process. We noted there were several adjustments that were recorded, and also that the Corporate Comptroller position is actually very important to the overall financial reporting during the financial statements, and not just the balance sheet, income statement, cash flow, but also the footnotes and the MD&A.

We put a comment in here that that position needs to be filled because having a person do two roles is a very difficult task. We also had some other recommendations as it relates to some of the documentation such as in performing a formal review of the completed financial statements but also the footnotes and the MD&A, making sure that the checklist that they had for year-end close is up to date, and making sure that the financial statement disclosures as well as the MD&A have what we like to call an auditing book that all the resource documentations are in there.

Ms. Youssouf stated that we are very happy Jay Weinman is coming to us.

Ms. Tiso continued and said that page six talks about liquidity. We came here during the June meeting as well as the October meeting that liquidity was one of the significant areas we spoke about. Just to highlight the past two fiscal years, the Corporation had break-even working capital and also received a significant amount of appropriations from the City of New York in the current year. It is something we wanted to highlight. I know that the Office of

Transformation was charged with Vision 2020, and Mayor Bill de Blasio's Transformation Plan is really supporting New York City Health + Hospitals Corporation, so it is just a comment to make sure that the organization is going to continue working with them in the future.

Mr. Campbell added that it is something this Board spends a lot of time as well as in the Finance Committee, and it is an ongoing issue, and we really know we need to change it up because you cannot operate a seven plus billion dollar enterprise that close, so thank you.

Ms. Tiso stated that the next comments relate to several observations around the patient accounts receivable area. I'm going to turn it over to Mr. Breen to highlight some of those comments.

Mr. Breen said that Patient Accounts Receivable, another significant area of the financial statements, an area we spend a lot of time on. First I want to point out that when we got to the financial statements, it was reasonably stated at year end, but as we worked through the process we saw potential improvements and observations.

First starting off as we worked through the process, the process does include aged unit accounts receivable, the different payor classes and there are historical cash collections. Those are some of the things that go in there. We observed that the person that was performing the analysis had moved on to a new position, and this one individual had the entire process. Obviously, a comment about, that this needs to transition, and there should be backup for this person as well. The second part related to that was the reviewer of the process, our understanding was retiring in the short term. It was a chance to really look at the process, and when you think about some of the controls you want to have over an estimate, you want to make sure -- are these assumptions supported? When I think about assumptions whether there are charge increases during the year, whether reimbursement rate increases, how does that factor into the estimate, and then also making sure that there is a historical look back on the prior estimate to make sure our process that we have in place is good. That happened during the audit. We got there at the end of the day. We were comfortable with the financial statements. It is just a matter of improvement in the process and documentation.

Mr. Breen stated that one of the assumptions I mentioned was historical cash collections, and when we did a sample of the cash collections that were being used as one of the assumptions in developing the AR, we found there were some duplicate postings related to MetroPlus. We were able to identify them and in conclusion that they were immaterial, but when you think about control with respect to that question, how management made sure that the reports they were using for the cash collections were complete and accurate. So ultimately we got there, an immaterial adjustment, but it just gives you an observation we got to really make sure these reports we were using and relying on are complete and accurate.

Third item relating to patient AR is credit balances. What happens is there are credit balances that sit in the AR account. These credit balances could relate to two things, one a mis-posting of contractual allowance or it could relate to a patient refund. There was work done during the audit that identified that -- the way it worked in the financial statement if it is a mis-posting, it should stay in the accounts receivable as a credit. If it's a refund, it should actually be re-classed over to accounts payable because you owe somebody back the money. It's been identified as nothing to do with AR anymore. It's actually an AP or accrued expense. The way it was presented in the financial statements was a reduction in AR, which is support that there are mis-postings. During the audit we performed test work on the credit balances to identify and support that conclusion, and we were able to support that conclusion, but we really need management to provide some more support on this area on a going-forward basis and analysis that supports the classification as a reduction to receivable. Those are the three observations in the patients account receivable.

Ms. Youssouf asked Mr. Anantharam if he had anything to add.

Mr. Anantharam responded that I agree with what Mr. Breen pointed out, and from everything that I have seen in the management report, we need a stronger accounting office and we need to beef up the staffing there. I do believe

that given where we are going with ERP and the consolidation of a lot of the accounting staff from the different facilities, we do not have all the resources that we need, and we are glad that Jay Weinman is coming on board. I already tasked him, and even before Jay Weinman I already tasked James Linhart with the responsibility of trying to figure out where the gaps were in our processes and trying to ensure that we find the right staff and build the right staff. I am positive and assured that the next go around, maybe not the next go around, we will be completely staffed and appropriately set. I accept that these are deficiencies we should not allow.

Ms. Youssouf asked if this is a balance sheet item and not an actual cash item, correct?

Mr. Anantharam answered that that is correct.

Mr. Campbell requested that Mr. Anantharam and Jay Weinman provide a strategy and plan in one of the upcoming Finance Committee meetings so he can update the Audit Committee.

Mr. Bukzin began his report by stating that I would like everyone to navigate over to page nine of the management letter, and the comment on the page is about MetroPlus. MetroPlus is fortunate enough to go through, I'll say two audits. It is a discretely presented component in the 6/30 New York City Health + Hospitals financial statements, and it also has a calendar year-end audit as well, so this is really focused on the procedures as it relates to the 6/30 period. I just wanted to highlight that it is an important part of even the 6/30 audit because it is a discretely presented in the financial statement within the consolidated report itself. While we were going through the process of backing in our audit procedures around that area, we did identify some areas for improvement, which were specifically focused around I'll say related party transactions with New York City Health + Hospitals in terms of some balances, and those balances should reconcile, and then also thinking through the subsequent event period.

That is information that comes to management's attention after the balance sheet date but relates to the balance sheet dates regarding whether or not there should either be an adjustment to the financial statements or disclosure in the notes of the financial statements. I think if the Committee recalls when we presented the results, we did actually highlight some adjustments that were related to this particular area, so the recommendation here is to really enhance the communication process between the Corporate Comptroller, Finance Office as well as the MetroPlus team, and it is important to the organization as well because there is quarterly reporting requirements, which of course take into account the results of the MetroPlus activity. That is the genesis behind the MetroPlus observations and recommendations.

Turning to page 10, you will notice that there is a little asterisk next to the comment that indicates that it is a repetitive comment from the prior period. It has to do with ensuring that there is a detailed accounts payable listing to support the general ledger balance, and due to some system limitations that can't be addressed at this point in time, but it appears as if there is a process in place that when certain systems go live in July of '17 that should be able to address and rectify the recommendation related to this reconciliation.

Ms. Youssouf commented that there is a little pressure on IT.

Mr. Bukzin said let's turn over to page 10, the topic here is tax matters. We are just providing a brief overview related to the tax-exempt status as it relates to MetroPlus being a 501(c)(3) entity, and the recommendation here is that when the tax return gets prepared, there should be a narrative description that articulates the compensation policies and procedures, and that was not included in the most recent return that was reviewed with the recommendation that it should be on a go-forward basis included as part of that.

The second element of the comment relates to Gotham Health, which is a related entity to the organization, and the comment gives a history of how it became a tax-exempt entity and then subsequently lost that status. Our tax professionals on the KPMG side actually worked very closely with the management team to assist with rectifying the situation. You will read through the recommendations going through a process, reinstating that tax-exempt status,

amending and filing tax returns. That's actually been in process, and it's a very specific date, looks like November 22nd, right before Thanksgiving this was taken care of. I just wanted to highlight that for the Committee.

On the bottom of the page, which rolls on to the next page, relates to one of our site-visit comments related to fixed asset depreciation. While we were doing our site-visit work, we selected a sample of fixed-asset additions, and one of the things we look for is whether or not it was placed for service, and when it is placed into service, that is when depreciation expense should be recorded. There were a couple of instances whereby it was categorized as placed into service and as such depreciation was recorded, but it wasn't actually placed into service, and it results in a system limitation in terms of the process to actually pay the vendor, so it has to slide over to this module in order to do that. To rectify the situation, there really should be additional controls and communication between accounts payable, the Comptroller's office and the facilities management dealing with the day-to-day fixed assets of the organization.

Mr. Anantharam reported that this item actually came up in a previous Internal Audit review, and the Comptroller's office is actually putting into place procedures in what the facilities need to follow to ensure that items are not put into play before the actual payment has been made.

Mr. Bukzin continued with page fourteen, this section relates to prior-year observations. The first one on this page deals with the review and approval of consultant costs. You may recall this came up in discussion in last year's meeting around enhancing controls in the area and closely monitoring and improving and tracking the consultant efforts. It speaks specifically to the EMR project, which was certainly a significant endeavor to the organization, so management's resolution status is that they have actually gone ahead and implemented a tracking tool whereby these consultants' time and effort is tracked on a real-time basis.

Page 15, another significant estimate to the financial statements and closely tied to the revenue streams of the organization deals with third-party payor reimbursement matters. During last year's audit, there were some observations that did result in some small adjustments to the financial statements, which we described here. We did recommend and management did implement controls in place to formally review the analysis and, again, enhance the communication and dialogue between the reimbursement team and the Comptroller's office.

Beginning on the bottom of that page, and it rolls to the next page, deals with the statement of cash flows. Just as a reminder for the Committee, there are actually two versions of the cash-flow statement. There's a direct and an indirect method, and it is not a simple mathematical exercise preparing that statement. It is often challenging, sometimes very unique circumstances and factors to consider when preparing it. One of the recommendations was let's make sure whoever is preparing it that there's someone above actually reviewing the details that creates the cash-flow statement, and that was implemented during this past year.

Bottom of page 16 and close to 17, the affiliation contracts comment. This was particularly focused related to the recalculations that transpire, and they do transpire on a lag basis but to ensure that that's happening as frequent and timely as possible. It could result in future adjustments, so that's why it's important to pay close attention to these recalculations. Management's resolution status does provide a very detailed update on where they stand with that process.

Turning to page 18, which covers some of our IT observations. We did have similar comments in the current year, similar in nature to comments related to user access. There are a few elements to that. There's access to the Data Center. There's even access assigned to individuals based upon their job responsibility and their job functions and making sure that there's controls in place that when there's changes or terminations or resignations that there's a periodic review of that access. That's the underlying message, similar to the prior year. I must have missed a page, but there are similar observations in the current year related to user access.

Ms. Youssouf commented that that is something that Internal Audits has found in a number of locations, and I know IT is actively working on it. It is a big project as you can imagine with all the facilities and many thousands of employees we have.

Mr. Bukzin continued and stated that sticking with the same theme of IT, we did have some practices related to password settings. To the extent that there is system limitations, enhancements although systems change. However, management is aware of these practices, and we'll certainly consider that going forward.

Jumping to page 22, one of the comments in the prior year related to a site visit. This had to do with the purchase order process, and I just want to remind the Committee that the key control here was the existence of a contract with the particular vendor, so those contracts were in place. This had to do with timing of which a purchase order is approaching its limit and perhaps needs to be adjusted or a new purchase order needs to be put in place. They have gone ahead and implemented policies and procedures to address that.

Ms. Tiso reported that the next section has several industry comments that we have been able to make in a lot of our health care systems. I'll touch upon some of them. A lot of these comments were already included in the prior year, but they are still applicable this year.

Starting on page 23, convergence in health care, obviously health care is at top of line and is changing daily, especially with the new President-Elect Trump and his new transformation that's going on. But one of the things we wanted to mention is that all health care systems are in the process of either merging with other systems, figuring out how they're going to increase revenue, and reduce costs. I think the Corporation has already taken steps with the 2020 Vision and Mayor de Blasio's Transformation Plan, so it's just something to highlight. The things that are going on in the news, it has like a two-day shelf life. Things are changing considerably. This whole thing with the Affordable Care Act, they're going to repeal and replace, nobody even knows where that's going to end up, but it's something to consider that the health care industry is evolving, and the Corporation really needs to continue to be ahead of the changes.

The next page, 24, talks about the New York State Delivery System, what we call DSRIP. It's a five-year plan. We talked about it last year. Year one and year two really was worried about getting the financial reporting up and running, receiving the funds, the whole administrative handling of the funds. Years three, four and five are going to be really based on performance measurements and quality metrics, so there is continue to have policies and procedures, look at your performance providers, are they handing in reports that require for you to fund them. There is a lot to continue looking at as it relates to DISRIP going forward.

Page 26, we spoke about this last year. The IRS finalized the 501(r) ruling to make sure the Corporation is in compliance with the rules and regulations.

The next one talks about internal control over qualified reporting. We all know that health care organizations are moving from volume patients in a hospital to quality, so internal controls over quality reporting is really important because you are going to be looking at quality metrics now, making sure that you hold all the documentations, that somebody is looking at the quality of the information coming into the systems. We envision that one day there's going to be audits over the quality reporting where now it's not happening. We do financial reporting audits. Now we think that going forward you'll have audits over quality reporting.

Bottom of page 27, Cyber Security. Obviously the health care industry is probably the leading industry of cyber-attacks. You probably see it in the newspaper daily. Obviously, health care has patient health information that cyber attackers love to get their hands on because it's significant money in their hands, so one of the things that's really important to understand is not if it's going to happen, when it's going to happen, and making sure that the organization

has enough policies and procedures in place, what are you going to do. Maybe have some mock trials figuring out if it happened, what you would do, making sure you're ready for that.

On page 28, Data Analytics, again, organizations are reducing cost increase in revenues, making sure you use data analytics in your organization to try help the reduce costs, and then last is telemedicine. I know a lot of organizations have begun going towards telemedicine to see how they can treat patients outside of the hospital. I am not sure where the Corporation is with telemedicine at this point. I know it is still new. There's a lot of organizations that are still trying it out. It is something to be added. It is something organizations are using. The other thing I wanted to mention, there is some edits that may still happen to this management letter. None of the comments and recommendations will change, but some nits and nats that we are still working through with the management team.

Ms. Youssouf stated great – thank you very much. I know especially with Mr. Anantharam being short of staff in there, I want to thank KPMG for their hard work during this audit and as always I think they have done a very thorough job.

Mr. Anantharam added that let me also echo those sentiments. '16 was a year in transition. There was a lot of movement across the system in terms of the Corporate Comptroller's office, but also leadership across Health + Hospitals System, so it was a particularly trying period to get all these accomplished, so I want to thank you all for your cooperation and work in this matter. In particular James Linhart and his team really stepped up to the plate to do the hard work.

Ms. Youssouf said thank you – now we are going to move on to Internal Audits and Compliance.

Mr. Telano saluted everyone and stated that we will start at page three of my briefing. It is a brief overview of the status of the audit being conducted by the City Comptroller's Office, just showing that the audit is still ongoing and is expected to take one year to complete, and it began in September 2016.

Moving on to page four is an audit of medical/surgical inventory controls at Jacobi. He asked for the representatives to approach the table and introduce themselves. They did as follows: Peter Lucey, Senior Associate Director Executive Director; Chris Mastromano, Chief Operating Officer.

Mr. Telano reported that we performed an unannounced count of 110 items of which there were errors in 77 percent of our counts primarily due to the warehouse staff not keeping accurate records. We also noted that management does not conduct frequent inventory counts. We believe that the reporting structure within the Materials Management department is contributing to some of these issues. Moving on to three, some of these issues have resulted in supplies being requested by the patient units in which there were zero items on the shelf, but the inventory system showed that there was stock on hand.

We also found that there is inadequate supply delivery for patient units on weekends, and employees filled the supply cabinets over the par levels to accommodate this, and as a result supplies are becoming misplaced or disorganized or becoming expired.

There was also a low volume of supplies needed by Behavioral Health, and as a result there was not a daily distribution, and once again Materials Management is having difficulty controlling those supplies.

We also noted that the head nurse or the designee of the user department does not sign off on the delivery of supplies acknowledging the accuracy of the items ordered. Lastly, there was a lack of controls over physical security. The doors to the rooms in the warehouse that store sensitive items, such as needles and syringes, are kept open and unlocked throughout the day.

We also found the main warehouse door was found open on numerous occasions, and medical personnel in other areas were walking in the warehouse unescorted. In regard to access to the exterior loading dock, we had Siemens's contractors and technicians and three employees from Human Resources, Surgery, Behavioral Health had

access to that. The supply cabinets, the closets within the units had keypad access codes which haven't been changed in a while, and also the swipe access system on Unit 6A was disabled due to a door malfunction.

Ms. Youssouf asked to give us a brief explanation of how you have fixed it or are going to fixed it?

Mr. Lucey responded that first we thank you and the team for coming in. They did point out a lot of very serious errors in the operation. We have since corrected most all of the security issues noted. We do spot check them.

The inventory counts that Mr. Telano referenced earlier, we have gone back with the staff reviewing the importance of inventory accuracy, maintaining the integrity of the system as it relates to the Oracle system with items going in and out. One of the recommendations of the Audit group was to conduct those spot checks. Those are now in place again having them report back when they're being conducted. The reporting structure of the department, and that's really at the crux of a lot of the problems. The structure was such as there have been some management changes over the past six months, seven months or so. We streamlined that. We have now taken some of these issues and rejiggered the organizational structure, management, responsibility of what's going on and taking place ending a lot of the cross-functioning that was going on.

The zero shelf items that again Mr. Telano referenced. We have eliminated those, the accuracy of the inventory counts, etcetera. The issue with sign-offs, that's been corrected, first the outpatient areas and then the inpatient areas. That started on or about 12/1 this year. The issue with security on the Simplex locks, those keypad locks that we use, they have now all been changed, and we've implemented a policy where they're all being changed every six months. We do that in consultations with the nurse manager on each unit. As well as the other security issues that were noted, doors have been fixed. I just spot checked that, needle room, Mr. Telano referenced, on 12/2 and just yesterday and previous to that. They have been secure each and every time as has the main door.

Ms. Youssouf commented that you are going to have spot checks on these because we have found this at a number of locations. Obviously senior management knows where they tape the locks so people could go in and out.

Mr. Lucey added that we are being tenacious on not letting the issues come back or management backslide if you will. We've put a lot of the control measures in place that we need to have there so we don't go through this again.

Mr. Martin stated that you two are two of my senior administrators, and I anticipate that moving forward this won't be an issue.

Mr. Campbell asked Mr. Telano if we share these audits with other facilities? Because I would like to think that there is no issue in any other hospitals, but my sense is that there are, and we do not have the bandwidth to do as many internal audits.

Mr. Martin answered yes, that it is Ms. Youssouf and my favorite sort of thing that lessons learned from one gets spread throughout the rest so we can ensure it is not replicated.

Mr. Telano continued onto to page six of the briefing. This was an audit of Service Grants Management at New York City Health + Hospitals/Lincoln. He asked for the representatives to approach the table and introduce themselves. They did as follows: Mahendra Patel, Grants Management, Central Office; Cheryl Simmons-Oliver, Senior Associate Executive Director, Public Affairs at Lincoln; Elisa Estrada, Grants Management, Lincoln; Barbara Marrero, Human Resources Director, Lincoln; Robert Bochicchio, Director of Finance, Lincoln.

Mr. Telano said that I will go over the findings first and then get your comments. The first comment, on page six is that Corporate Grants Management does not maintain a master list of all grants throughout the corporation. We found also that they do not maintain copies of contracts, that they were located at various departments within the Corporate Office and within Lincoln.

We also noted that one contract agreement was negotiated and agreed upon by the Finance Assistant Director at Lincoln through the New York State Grants Gateway System, and there was no documentation provided to

Corporate Grants Management or any other party regarding this grant. We also noted that funds were not being expended on many of the grants, some until the final month of the quarter of the reporting period. As a result there were some vacant positions up until ten months into the 12-month grant period. We also had \$290,000 in grant funds not used for six service programs.

Moving on to the bottom of page six, we found that contracts were not finalized in a timely manner. Seven of 23 programs reviewed were operating six through 24 months without a fully executed contract in place.

Turning to page seven, all grant applications were submitted on the actual application deadline date rather than two weeks prior. As a result, a grant application was denied due to an incomplete proposal and failure to adhere to grant application guidelines.

Ms. Youssouf stated that we don't need everyone to speak, but whomever you feel is most appropriate to explain what you are doing to correct these items, please.

Mr. Anantharam said let me open up on the corporate side. Most of the findings are on the corporate level, and Mr. Patel is here from Finance Office to add commentary when needed. I agree on all these issues with the Audit Department about having it take place at Central Office where all the contracts reside. The issues of not spending all of the money for lack of personnel is something that we have to fine tune in our process as we currently go through our attrition program and trying to ensure that we do not lose personnel, which actually produce revenues and at the same time have grant allocations.

Ms. Youssouf asked if that is Finance's responsibility?

Mr. Anantharam responded that the process that we currently have in place on looking at where attrition happens and where we hire goes through a review process between Finance and Operations to identify those that are critical hires and are necessary to come on board. Most of the focus on the critical hires have been on health and safety issues and also in areas where we need primary care physicians and Behavioral Health staff. We haven't focused on administrative staff as much, so we need to fine tune that process and ensure that some of that requirements of having a reduced staffing level also results in the facilities not requesting staff. We need to go through a process of ensuring that the communication between us and the consumers is clear on how going forward we need to do hiring. I don't expect that to be a solution we will have in place tomorrow but in the ensuing months for certain.

Ms. Youssouf said that I'm a little confused. These are grants for one institution, so the grants are administered by the Central Office.

Mr. Anantharam answered that the grants go through a process of review by the Finance Division.

Ms. Simmons-Oliver added that we want to thank the Audit team for helping us identify weaknesses that were in existence in our granting process. I along with my team are new to HHC and with the audit team we were able to put together what we felt would be an effective action plan to address the needs that were identified for us. I have with me my Grant Manager, Ms. Estrada and she is going to actually speak about our new policy and procedure, and we brought an end line, part of our corrective action plan, it was to come in line with the policies and procedures that are in existence.

Ms. Estrada stated that this in response to C-1. To extend my current policy, I am going to schedule a program application huddle to take place every two days to review the progress or any element to the progress in any of the areas. The participating teams in the huddle will be the fiscal analyst, the program manager, an HR representative and myself. I'm going to be using a monitoring report to control and monitor the various aspects of the grant application process, and if any holdup occurs, it will be escalated to Central Office. I'm also going to be meeting on a routine basis with the Associate Executive Director who manages the Grants Department at Lincoln to review and discuss the application process.

Ms. Youssef said thank you for taking swift and personalized action to putting something in place. We appreciate that very much.

Mr. Telano continued with page eight, an audit of the Surgical Solutions contract was conducted at Bellevue. Mr. Paul Albertson will come to the table to discuss this.

Mr. Albertson introduced himself as Vice President of Supply Chain Services and Operations.

Mr. Telano reported that overall we noted inconsistencies during our review of the cost analysis for the contract and billing for procedures conducted by Surgical Solutions. We also found a lack of documentation and inadequate controls related to the payment of invoices and staff personnel files.

Mr. Albertson commented that our Supply Chain Services Office assumed the responsibility for the contract this summer. Our standard Supply Chain practice is, whenever we have a large dollar contract vendor that we have regular business meetings with them. We started that with Surgical Solutions this summer to be able to start standardizing their business practices as the agreements are facility-based and there is unevenness between them all. With the responses from the Internal Audit Offices, we also found some other opportunities that helped us to better understand some of the other practices that are taking place. To be able to standardize this in all the business and clinical practices, Mr. Joe Wilson, who leads our Strategic Sourcing for Supply Chain, has a monthly meeting with a multidisciplinary team from all of the facilities who have Surgical Solutions operating within their offices where we are standardizing the metric, the services, the staffing process, and also the procedure.

Our anticipation is that in January, we will finish our standardized approach, and then we will have a meeting with Surgical Solutions together with all of our clinicians. Then we will begin standardizing the practice and then having monthly reports that we will be receiving on the metrics as it relates to all of those various issues that Mr. Telano's team has pointed out. I think it's an opportunity for us to really get more synergy on the practices, and it will also help us answer some of the questions that are still out there as it relates to their overarching value and the return to us in that system.

Ms. Youssef said that that's great and I know you have been working on this for a while. I would like to request that maybe in January you come back with a brief presentation to the Audit Committee about what system you put in place and what you found out if it's January or February, whatever is appropriate.

Mr. Martin asked if they were meeting in January? To which Mr. Albertson answered yes.

Ms. Youssef stated that perhaps February is better, but I'm really happy that frankly it's all now coordinated and somebody is really doing the oversight that we are supposed to be doing on such a large contract.

Mr. Telano continued with page nine of the briefing, the last report is of fixed assets at East New York. He asked for the representatives to approach the table and introduce themselves. They did as follows: Elsa Cosme, Chief Financial Officer for Gotham Ambulatory Care; Mr. Anthony Manwaring, Controller; Michele Lewis, Interim Administrator.

Mr. Telano reported that the first finding has to do with the previous deputy executive director. She was approving purchases for items that were used in her own office. We found furniture totaling almost \$18,000 in which she approved for herself. Moving on to part B, we found that there was minimal controls over the fixed assets as it relates to the financial aspect of it. We could not locate two items, a 50" flat screen television and a laptop that were both purchased in 2015. Seven items were not in the location of the financial fixed asset management report, and three items did not have proper tags, and lastly we found \$121,000 worth of expenses that should have been capitalized instead of expensed.

Ms. Cosme stated that I'm the new CFO for the whole Gotham facility. What I'm doing is standardizing and creating a standard process to take it across all six facilities so that we can all start looking at things at the same time,

reviewing, seeing the problem and fixing it, so I thank you for this. I was not part of the audit, but when the comments and the findings came out I was at Gouverneur and right away I called everybody in finance at the facilities so they can see what is being presented and how we can fix it.

We have done a few things. In terms of the first finding of the approval process, we have already created an approval pathway where we have Mr. Steve Ballstein and Sarah Killian to be the last or the final approval for anything. I am approving and reviewing the accounts and making sure that it is appropriate, that we know it is a fixed asset sum. Some of the facilities are not aware, so we did an educational on what is the cost, why should they be a fixed assets versus a miscellaneous code for it, so we already went through that process.

We gave each of the facility managers a chart of accounts so they can actually go back with a description of everything, and we are going to be talking to them on a quarterly basis so they know what we have, and we are going to start also reviewing all facility costs to ensure that if we miss something in the process, we can catch it and re-class it before we get into audit. That is what we are trying to do and we appreciate it, and I know many people say Internal Audits is our best friend...trust me, I do believe that.

Ms. Youssouf said that that makes me so happy.

Mr. Telano said me too.

Ms. Youssouf said thank you and I am very glad, and I understand that the change in the senior management related to these issues has gone really well, and we welcome the new team and thank you very much.

Mr. Telano said that that concludes his presentation.

Ms. Youssouf turned the meeting over to Wayne A. McNulty, Senior Assistant Vice President and Chief Corporate Compliance Officer within the Office of Corporate Compliance ("OCC").

Mr. McNulty saluted the Audit Committee of the NYC Health + Hospitals Board of Directors (the "Audit Committee" or the "Committee") and introduced himself as Wayne McNulty, Chief Corporate Compliance Officer. He continued on to page three of the Corporate Compliance Report (the "Report"). Mr. McNulty stated that the first week of November - November 6th through November 13th - was National Corporate Compliance and Ethics Week. He explained that the theme for this year's Corporate Compliance and Ethics Week was *Provide, Protect and Prevent*. He elaborated as follows: *Provide* the tools necessary for training NYC Health + Hospitals' workforce, *Protect* NYC Health + Hospitals from costly compliance and ethics mistakes; and *Prevent* wrongdoing at all levels at NYC Health + Hospitals. He informed the Audit Committee that, during Compliance Week, educational events took place throughout the System. Mr. McNulty thanked all workforce members System-wide for participating in Corporate Compliance and Ethics Week.

Mr. McNulty continued by turning to page five of the Report, and, in sum and substance, informed the Audit Committee that since the last time Committee convened on November 8th, the OCC learned that there was one individual who was excluded from the Office of the Inspector General's ("OIG") list of excluded providers. He stated that the excluded individual was a nurse. In summary, he reported to the Committee that the excluded individual's Texas nursing license had been lost, which ultimately led to the excluded individual being placed on the OIG excluded list. In general, he advised the Audit Committee that the excluded individual was placed on administrative leave, and if the exclusion status of said individual was not resolved within 75 days, the excluded individual would be separated from services.

Mr. Brezenoff asked to give that time frame again. Mr. McNulty responded, in sum and substance, that there is a 75-day period where excluded providers are allowed to cure whether or not the exclusion is a mistake, but during that 75-day period they cannot work.

Ms. Keller asked if they get pay. To which Mr. McNulty responded no.

Mr. McNulty turned to Section three on page five of the Report - privacy incidents and related reports for the third quarter of calendar year 2016 ("CY16"). Mr. McNulty stated that for the third quarter of CY16, the OCC received 30 reports of privacy complaints, 13 of which, he elaborated, were determined to be violations of the privacy operating procedures – and four of these were breaches of protected health information. Mr. McNulty continued by discussing a breach that occurred at Coney Island Hospital ("NYC Health + Hospitals/Coney" or "Coney"), which he deemed significant in nature. He advised the Audit Committee that five Coney employees inappropriately accessed the record of a person of public notoriety. In summary, he stated that the investigation into the subject incident revealed that there was no business purpose for such access. Mr. McNulty added that the responsible employees were retrained, and that the imposition disciplinary penalties on the employees that were involved was under review.

Mr. McNulty reviewed the next incident, which occurred at Bellevue Hospital Center ("NYC Health + Hospitals/Bellevue" or "Bellevue"). On a whole, he informed the Audit Committee that the subject incident involved an employee-patient, who was in possession of three charts in their locker.

Ms. Youssouf asked a patient or an employee?

Mr. McNulty answered an employee's locker.

Mr. McNulty explained that Hospital Police was performing a non-related investigation of an employee and when they went into the employee's locker, they discovered three patient charts in that locker that did not belong to the employee. Mr. McNulty stated that one chart was the record of the employee's significant other; one chart was the record of the employee's son; and one chart was the employee's medical record. He explained, in pertinent part, that the employees conduct was a breach of protected health information. He advised the Committee that the employee was terminated.

Ms. Youssouf asked if the prior group have physical copies of the charts? To which Mr. McNulty answered no, the prior group accessed the records inappropriately.

In general, Mr. McNulty stated that audit checks are performed regularly on patients, especially patients of notoriety to see if anyone has accessed their record inappropriately. In summary, he further stated, if a workforce member is not part of the treatment team or the direct administrative team that assists that treatment team, then said workforce member has no reason to access that record.

Mr. McNulty continued and informed the Audit Committee that at Lincoln Medical and Mental Health Center ("NYC Health + Hospitals/Lincoln" or "Lincoln"), a minor who was scheduled for an appointment received the wrong appointment slip, and therefore a breach notification was provided to the patient whose information the minor and the minor's parent came in contact with.

Mr. McNulty continued by describing an incident at Harlem Hospital Center ("NYC Health + Hospitals/Harlem" or "Harlem"), which he described as a more serious matter. He informed the Audit Committee that an attending physician permitted his non-workforce member wife to be present during a procedure, which was a breach of protected health information. He advised the Committee that the physician no longer worked at Harlem. In sum and substance, he further advised the Committee that the Office of Legal Affairs was being consulted with as to whether it was appropriate to refer the subject incident to the Office of Professional Misconduct.

Mr. McNulty then discussed the compliance reports for the third-quarter of CY16. He advised the Committee that 93 compliance complaints were received during the third-quarter. One, he explained, was a priority A report. He advised the Committee that a priority A report was a report of great significance. He further advised the Committee that there were 44 priority B and 48 priority C during the same time horizon. As for the Priority A report, in summary he advised the Committee that the same was an ongoing investigation and could not be discussed. Mr. McNulty then

went on to highlight that over 54 percent of the compliance complaints received in the third-quarter came through the OCC's confidential compliance help line where employees can report compliance issues anonymously.

Mr. McNulty then moved on to page 13 of the Report and updated the Audit Committee on the System's information governance and HIPAA privacy operating procedures. Mr. McNulty explained to the Committee that under 45 CFR §164.316, the System is required to promulgate HIPAA operating procedures and to routinely update those operating procedures. He further explained that there are also consistent regulations under New York State law that require the same. He stated, in general, that a review of all existing HIPAA operating procedures was performed, which led to the conclusion that the following three operating procedures required revision:

- The breach response and notification operating procedure;
- The minimum necessary operating procedure (which he explained to the Committee means that when the System discloses information for any purpose that it is the minimum necessary in light of reason and disclosure); and
- The Business associate agreement operating procedure (which he explained means that whenever the System does business with its business partners and said business partners have the System's protected health information, such business partners must secure that information).

With regard to the aforementioned operating procedures, Mr. McNulty stated, in pertinent part, that: (i) although the above-mentioned operating procedures currently meet legal requirements, they could be updated for control purposes; and (ii) the process of updating these procedures had commenced.

In sum and substance, Mr. McNulty advised the Audit Committee of the following:

- Compliance operating procedures were being reviewed and Operating Procedure 50-1, which governs the compliance and ethics program throughout the System, was under revision;
- The Corporate Compliance plan was under revision; and
- Operating Procedure 120-19, which covers the System's Records Management program, was being reviewed to determine whether it required updating, and that he would brief the Committee on the same when he returned in February.

There being no further questions by the Committee, Mr. McNulty concluded the Report.

Ms. Youssouf then stated that they going into executive session.

Ms. Youssouf stated that they are back from the Executive Session; they discussed matters that were confidential and related to patient care and quality assurance as well as ongoing investigations.

There being no further business, the meeting was adjourned at 3:25 P.M.

Submitted by,

Ms. Emily Youssouf
Audit Committee Chair



**AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS**

**Corporate Compliance Report
February 10, 2017**

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I. Human Research Subject Protections and Compliance Program Audit

Background

- 1) In late 2010 the Office of Legal Affairs and the Office of Medical and Professional Affairs determined that the System’s research policies and procedures required revision. These offices moved forward with a multidisciplinary collaborative approach to develop revised research policies and procedures.
- 2) Additionally, after conducting an internal enterprise-wide risk assessment across the System, it was determined that human subject research was a compliance risk area that required attention. To mitigate these risks, the Office of Corporate Compliance (“OCC”), Office of Research Administration (“ORA”), Office of Medical and Professional Affairs, and Office of Legal Affairs continued to work on the development of a System-wide research operating procedure.
- 3) A System-wide research policy and procedure, codified in System Operating Procedure No: 180-9, (the “OP” or the “OP 180-9”), *NYC Health + Hospitals Human Subject Research Protections Program Policies and Procedures*, covering the life cycle of a human subject research studies was developed. This OP was approved by official resolution of the NYC Health + Hospitals Board of Directors on November 20, 2014 and signed and issued by the System’s President and Chief Executive Officer on April 29, 2015. Note that, OP 180-9 replaced a 1991 Board-approved Policy (*HHC Clinical Investigation and Research Policy and Guidelines*, May 23, 1991) governing human subject research.
- 4) In 2016, the OCC initiated a review of human subject research practices at the System to validate that the new processes and procedures embodied in OP 180-9 were fully implemented across the System. Such review is the subject of this Report.

Implementation of OP

- 5) After OP 180-9 was adopted, it was distributed to the workforce members in the following manner:
 - via email;
 - posting on the System’s intranet; and
 - as required by OP 180-9, through face-to-face training meetings at all System facilities where research is conducted.
- 6) The Senior Director of the ORA conducted System-wide training on human subject research by meeting with each affected facility to distribute the OP and to train research Investigators, study teams, and administrative research staff on the new processes. The Senior

Director of the ORA confirmed that this training was initiated in June 2015 and completed by September 2015.

Scope of Compliance Review

7) A sample of 30 clinical research studies (“Studies”) were audited against seven key research areas contained in OP 180-9 to ensure that the OP was being followed and that sufficient internal controls were implemented at ORA and the facilities to minimize the risks associated with human subject research activities. The seven key areas of OP 180-9 that were reviewed by the OCC were as follows:

- Development and implementation of policies and procedures and standards of conduct related to Human Subject Research (“HSR”);
- Designation of persons and departments within the System responsible for operating and monitoring aspects of HSR under OP 180-9;
- Appropriate and ongoing training and education for individuals involved in research;
- Communicating and responding to allegations of improper/illegal activities or other systemic problem areas;
- Use of audits to monitor and control identified problem areas;
- Implementation of remedial measures when misconduct or financial conflicts of interest are identified; and
- Taking corrective action when research misconduct or fraud, waste or abuse is detected to ensure the System’s commitment to detecting and deterring non-compliant research conduct and fraud, waste and abuse in human subject research context.

8) In addition to a focused documentation review, interviews were conducted with the individuals and departments involved with the Studies, to ensure that there was sufficient knowledge and understanding of the new and continued expectations required by OP 180-9. The main stakeholders identified during the reviews and identified in the specific Studies included, without limitation, Principal Investigators (“PI”), Facility Research Coordinators (“FRC”), and Office of Research Administration (“ORA”) staff, as well as finance, pharmacy and other support staff, as required.

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9) Although it was noted during the review that some facilities were still transitioning from either the ReASOn process flow software or paper documentation to the STAR process flow and document storage software, the facilities were held accountable to follow the OP processes. As STAR is a relatively new system and ReASOn is being sunset, it was sometimes difficult to locate information even with the assistance of the Facility Research Coordinator (“FRC”). However, as long as the staff were able to produce the paperwork with the appropriate information and dates, the process was considered compliant even if STAR was not fully implemented at the facility.

Compliance Review Process

10) For the review, a statistically significant sample of 30 Studies were identified, representing Studies at six acute facilities and two Gotham Health FQHC facilities.¹ The review included file reviews to determine if the 30 studies followed the OP 180-9 process flow and contained documentation required by OP 180-9. The personnel interviewed were those individuals at the facilities who were involved with the Studies under review.

11) The review included an audit of whether ORA and the facilities were following the process map contained in OP 180-9, including any accompanying documentation.

Findings

Compliance with OP 180-9 Process Flow and Documentation Requirements

12) As noted above, the review included an audit of whether ORA and the facilities were following the process map contained in OP 180-9 and had the required documentation. After a review of the 30 studies, it was found that 2 of the studies did not meet the criteria for IRB review and therefore were deemed exempt from IRB approval process. Therefore, these two Studies were not part of the OCC review. .

13) Of the 28 remaining studies, there were 4 process flow and documentation findings identified and subsequently resolved:

- In one Study (Kings), the required continuing IRB approval documentation was missing from the STAR system. The IRB request for approval was, however, submitted on time and the approval was subsequently found and uploaded into STAR.

¹ The facilities covered in the review were Harlem Hospital Center (“Harlem”), Bellevue Hospital Center (“Bellevue”), Elmhurst Hospital Center (“Elmhurst”), Jacobi Medical Center (“Jacobi”), Kings County Hospital Center (“Kings”), Queens Hospital Center (“Queens”), Morrisania Diagnostic and Treatment Center (“Morrisania”) and Segundo Ruis Belvis Diagnostic and Treatment Center (“Belvis”).

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- In one Study (Bellevue), there was an approved protocol modification that instituted the use of a professional transcriber for audio interviews of patients but no funding or revised budget information was identified for the increased cost.
- In one Study (Bellevue), the Study was listed as active in the STAR database but upon review, it was noted that the principal investigator (“PI”) had already closed the Study with the IRB.
- In one Study (Morrisania), it was noted that the IRB continuing review approval date was incorrect in STAR. The incorrect date was due to a STAR technical issue and since there was no active FRC assigned to this facility at the time of both the error and the review, the incorrect date was not identified.

Training on OP 180-9

14) During interviews conducted by the OCC it became apparent that many of the PIs or Study team members were not aware of the new OP 180-9 content. Specifically, the OCC observed the following:

- Although the PIs were familiar with the IRB approval process, most were not aware of full scope of the new OP requirements;
- Most PIs interviewed were unable to speak to the increase in research record retention or the changes in the continuing review approval process for the System, which includes, for example, the uploading of the IRB continuing approval letter within 10 days after the expiration date of the original IRB approval; and
- Many of the PIs were unaware of the training that was given by the ORA, or were not available on the date that it was offered at their facility.

15) All of the FRCs and finance support staff were aware of the new OP but were not familiar with the additional expectations related to their job functions. This is especially significant for research studies where third party billing or invoicing is involved. The OCC’s review of this topic revealed that no formal training on these new skill requirements had been identified for either the FRCs or finance staff.

Recommendation:

Formal training on the new skill requirements found under OP 180-9 should be implemented to cover FRCs and finance staff.

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Management Response:

The ORA will continue to work to develop a standard process across the System including the training and education of these individuals.

16) The need to implement more frequent, widespread and ongoing training on OP 180-9 for all research investigators, Study teams and administrative staff was demonstrated at every facility. The OCC review became an opportunity to continue the training process. However, the ORA, per the OP, is responsible for ensuring that the research workforce is trained appropriately. They are required to formally identify the mandatory training requirements for all new and active researchers.

Recommendation

Focused training on OP 180-9 must be considered a requirement to ensure compliance and mitigate risk for human subject research and billing.

Management Response:

The ORA will continue to implement its training efforts to ensure System compliance with research procedures and billing.

Use of the STAR Process Flow and Documentation Software

17) The OP incorporated the use of an electronic database for maintaining and tracking research information at the facilities. STAR, which is the current software used to meet this requirement, has very detailed work flows that require all necessary documents and approvals before a Study can proceed to the next level of approval. It is important to note that, because of the highly regulated nature of research, which has been followed by the System for many years, the critical IRB workflow processes, such as timely continuing reviews and documentation requirements and modifications for protocol changes, were already being followed throughout the facilities.

18) Review of the Study documentation and the related interviews demonstrated a basic understanding of the requirements for completing the research process. However, it was clear that the STAR submission process is still somewhat confusing to many of the users as the OCC documented the following findings:

- User errors that affected the integrity of the data in the system including, without limitation, errors in funding and budgetary numbers were identified;
- incorrect IRB documents were uploaded into the STAR system;

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- staff showed Studies as active, although they were no longer with the System; and
- contractual information was not always available.

In addition to the above, users expressed concern that it was difficult and time consuming to locate information, especially modifications in the STAR system, due to the unique numbering system that is being utilized and the inconsistent locations and fields being used to upload information.

Management Response:

The OCC was informed by the ORA that improvements will be made on STAR system going forward to better control user errors.

Billing and Finance

19) All facilities were able to speak to the utilization of clinic code 088, which is the prior financial control implemented to prevent inappropriate research billing. Some of the facilities have developed local systems to review their research payments against invoices; however, no standard process was identified for reconciling the billing data to actual payments to ensure that all research related revenue is being received across the System. Since the ORA is responsible for the administration of contracts for the research studies, the facilities are not always directly involved with the payment process or contract details. Having minimal controls over the tracking of payment information could result in the loss of potential revenue and/or accepting overpayments. Implementing standardized systems for tracking and reconciling expenses and revenue, as required by OP 180-9, will ensure that NYC Health + Hospitals will receive all monies it is entitled to. Implementing systems to ensure that all billable services are identified and all payments are reconciled will be developed by collaboration among ORA, Corporate Finance, and Enterprise Information Technology Services (“EITS”).

Recommendation

ORA should implement: (i) standardized systems for tracking and reconciling expenses and revenue, as required by OP 180-9, to ensure that NYC Health + Hospitals will receive all monies it is entitled to; and (ii) implement systems to ensure that all billable services are identified and all payments are reconciled.

Management Response:

A new workflow will be developed by ORA, in consultation with Finance, as necessary, that will readily address and resolve these issues,

Conclusion

20) In conclusion, the OCC found significant compliance throughout the System with the basic intent and controls of OP 180-9. Specifically, there was increasing compliance of the workforce with the workflow process identified in the OP as they received additional training. For those facilities that are more closely mirroring the process, it has been successful in minimizing risk and errors. With additional training for the Study teams, FRCs and finance support staff, substantial compliance with OP 180-9 will be realized and the System-wide potential risk associated with human subject research risk will be further minimized, more readily detectable, and, controlled.

II. CMS Medicare Parts C and D General Compliance Training Required by Contractual Obligations with Medicare Advantage Organizations

Background and Legal Requirements

1) Pursuant to CMS regulations, Medicare Advantage Organizations (“MAOs” are required to adopt and implement an effective compliance program designed, in pertinent part, to prevent, detect and correct instances of: (i) non-compliance with CMS requirements; and (ii) fraud waste and abuse.² Examples of MAOs include MetroPlus, Aetna, Fidelis, GHI, Healthfirst, and United Healthcare, all of which have a provider agreement with the System. Note that, in its role as a provider under contract with these and other MAOs, the System is classified or otherwise referred to as a *First-Tier, Downstream, or Related Entity* (“FDR”). As a FDR, the System is indirectly covered under the CMS training requirements by way of its provider agreements with various MAOs.³

2) One of the required elements of a MAO compliance program is the establishment and implementation of effective training and education between the MAO and its FDRs – including the System. In sum and substance, such training includes the mandatory completion of the *CMS Medicare Parts C and D General Compliance Training* (“CMS Compliance Training”) (see Attachment “A”) by all of the System’s Workforce Members (e.g., employees, affiliates, medical staff members, trainees, students, volunteers, and other personnel whose System activities, duties and/or functions are under the direct control of the System whether or not they are paid directly by the System), as well as all of the System’s Business Partners (e.g., vendors, contractors, subcontractors, and other third-parties under contract or other agreement with the System) who or that:

- provide billing or coding functions;

² See id. at § 422.503 (b)(iv).

³ See 42 CFR § 422.503 (b)(iv)(C)(3).

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- furnish, order, prescribe or otherwise provide healthcare products and services;
- monitor the healthcare provided by the System;
- establish and administer the System’s formulary and/or medical benefits coverage policies and procedures;
- exercise decision-making authority on behalf of the System (e.g. clinical decisions, coverage determinations, appeals and grievances, MAO enrollment/disenrollment functions, processing of pharmacy or medical claims); or
- engage in activities, functions, and duties that may place the System in a position to commit significant noncompliance with CMS program requirements or health care fraud, waste, and abuse prohibitions.

Action Taken by the System to Meet its MAO Contractual Requirements

3) In order for the System to satisfy these CMS and MAO contractual requirements, on December 29, 2016 the Office of Corporate Compliance (“OCC”) distributed via e-mail CMS Compliance Training materials to all System Workforce Members and Business Partners. The training materials, which included over 40 training slides that covered general compliance training as it relates to Medicare Parts C and D, covered the following key topics and learning objectives:

- How a compliance program operates (with a particular attention focused on ethical behavior); and
- How compliance program violations should be reported.

Implementing CMS Compliance Training Prospectively

4) Moving forward, in order for the System to continue to meet its MAO compliance training contractual obligations, the following steps will be executed:

- The CMS Compliance Training has been incorporated into the updated Physician, Health Professionals, General Workforce Member, and Board of Directors compliance training modules slated for release in early March. These modules must be completed annual by these designated groups; and
- The OCC will also continue to distribute, on an annual basis, the CMS Compliance Training materials to its Workforce Members and Business Partners in the same or similar manner as it did in December 2016.

III. Monitoring of Excluded Providers

Overview of Regulatory Requirements

1) Federal regulations provide that “no payment will be made by Medicare, Medicaid or any of the other Federal health care programs (*e.g.*, Medicaid, Medicare) for any item or service furnished . . . by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.”⁴

2) Similarly, New York State regulations also provide that “no payments will be made to, or on behalf of, any person for the medical care, services or supplies furnished by or under the supervision of the person during a period of exclusion” from participation in the Medicaid program.⁵

3) Further, to maintain an active enrollment status in the Medicare program, NYC Health + Hospitals must certify that it does not employ or contract with individuals or entities that are “excluded from participation in any Federal health care programs for the provision of items and services covered under the programs.”⁶

4) To adhere to these regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General (“OMIG”)⁷ and the United States Department of Health and Human Services Office of the Inspector General (“OIG”), each month the Office of Corporate Compliance (“OCC”) confirms that none of the NYC Health + Hospitals’ (the “System”) workforce members (*e.g.*, employees, board members, affiliates, personnel, volunteers, and medical staff members), vendors, and DSRIP partners are excluded from participation in Federal healthcare programs such as Medicaid and Medicare.

5) In addition, to ensure business is not conducted with terrorist organizations or other sanctioned entities, all United States incorporated entities are required to comply with

⁴ Scope and Effect of Exclusion 42 CFR § 1001.1901 (b); *see also* 42 CFR § 1002 (the authority of State agencies to exclude on their own initiative, regardless of whether the OIG has excluded an individual or entity).

⁵ *See* 18 NYCRR 515.5; *see also* 18 NYCRR 515.2(b) (7) (includes employment of and submitting a claim for services rendered by a suspended or disqualified from participation in the program as an unacceptable practice under the medical assistance program and conduct which constitutes fraud or abuse.)

⁶ *See* 42 CFR § 424.516 (a) (3); *see also* 42 CFR § 424.535(a) (2) (regarding CMS’ option to revoke enrollment and billing privileges due to exclusion from Medicare, Medicaid or any federal program). *See also* 42 USC 1320c-5 (Regarding obligations of health care practitioners and providers and the Secretary of Health and Human Services’ right to exclude a person or entity for failing to meet the obligations.)

⁷ DOH Medicaid Update April 2010, Vol.26, No. 6 and the NY OMIG webinar #22 OMIG Exclusion and Reinstatement Process, <https://omig.ny.gov/resources/webinars/811-omig-webinar-22> [Slide 20 (Sept 2014), accessed Feb. 2, 2017.]

regulations of the Office of Foreign Asset Control (“OFAC”).⁸ Therefore, the OCC also screens all NYC Health + Hospital Workforce members, vendors and DSRIP partners against all OFAC databases designed to halt terrorist and other illegal funds from circulating.

Exclusion and Sanction Screening Report for November 29, 2016 through February 6, 2017

6) Since the OCC last reported excluded provider activities at the December 8, 2016 Audit Committee, the following excluded workforce members have been identified.

- *OMIG Exclusion of NYC Office of Labor Relations’ Social Worker*
 - On December 23, 2016, the OCC was informed that a Social Worker, assigned to provide NYC Health + Hospitals employees with counseling under the System’s Employee Assistance Program, was excluded by OMIG, effective August 23, 2015. The excluded individual was not on OIG’s exclusion list.
 - The Social Worker is employed by NYC’s Office of Labor Relations (“OLR”) and is assigned to counsel NYC Health + Hospitals employees pursuant to a contract with OLR. The excluded individual worked part time, from November 16, 2016 until December 23, 2016 at Bellevue, Metropolitan and Harlem Hospitals, for a total of 23 days. Upon discovery of his OMIG exclusion, this OLR Social Worker’s services were immediately suspended. The excluded individual was removed from OMIG’s exclusion list in January and has returned to his NYC Health + Hospitals position.
 - Expenses related to the excluded individual’s services will be reflected as non-reimbursable costs on the applicable cost report, when it is filed in June 2017. The OCC is currently evaluating, in consultation with outside counsel, whether any self-disclosure to the appropriate regulatory bodies is required.
 - In addition to that noted above, NYC Health + Hospitals’ contract with OLR will be revised to add the requirement that OLR ensure the staff they provide the System are not excluded providers. In the meantime, the Director of OLR’s Employee Assistance Program agreed to conduct exclusion screening on all current and future staff they assign to us.

⁸ See Frequently Asked Questions: **Who must comply with OFAC regulations?** United States Treasury website, https://www.treasury.gov/resource-center/faqs/Sanctions/Pages/faq_general.aspx [accessed Feb. 1, 2017.]

➤ *OIG and SAM Exclusions of Lincoln Hospital Recovery Center Acupuncturist*

- On January 10, 2017, the OCC was informed that a Coordinating Manager and Acupuncture Supervisor, who works at Lincoln’s Recovery Center Outpatient Chemical Dependency Program, is on the OIG exclusion list and the System for Award Management (“SAM”) exclusion list. It appears that the exclusion stemmed from prohibited conduct that occurred approximately thirty year ago. The excluded individual worked from December 27, 2016 until January 11, 2017 when he was suspended without pay. The excluded individual has been provided 75 days to arrange to be removed from both exclusion lists.
- The Lincoln Hospital Human Resources staff member, responsible for conducting this employee’s pre-employment exclusion screening, identified his name on the exclusion lists. The excluded individual, reportedly unaware that his/her prior conduct resulted in his/her exclusions that remained on record, when questioned about them, he denied being on the exclusion lists when questioned about the same. The Human Resources staff member has been counseled that Compliance must be contacted to assist in evaluating such denials in the future.
- While substance abuse programs are permitted to provide acupuncture as an adjunct therapy, it appears not a billable service. Expenses, relating to this Acupuncturist’s salary and benefits, will be reflected as non-reimbursable on the applicable cost report, when it is filed in June 2017. The OCC is currently evaluating, in consultation with outside counsel, whether any self – disclosure is required.

➤ *OMIG Exclusion of Metropolitan Hospital Volunteer*

- On January 20, 2017, the OCC was advised that a Metropolitan Hospital Center Physician Volunteer, appeared on OMIG’s exclusion list, effective November 27, 2016.
- Metropolitan Hospital personnel were aware of the Physician’s related license suspension and the 700 hour community service requirement he agreed to by Consent Order, but was not aware of his OMIG exclusion.
- Metropolitan Hospital’s personnel and the Physician Volunteer were informed that he cannot work at NYC Health + Hospitals in any capacity until he is removed from OMIG’s exclusion list. In collaboration with the Office of Legal Affairs, investigation of the initial screening of this

Physician is underway. We are also evaluating whether any self-disclosure or cost report adjustments for volunteer expenses are required.

- 7) The following is updated information on self – disclosure and voluntary refunds related to exclusions reported in prior Board Reports.
- *OMIG Exclusion of Kings County Nurse and Required Self-Disclosure*
- In February 2016, the Audit Committee was advised about a Kings County Nurse’s exclusion from Medicaid. This Kings County Nurse was placed on inactive status, without pay, effective December 30th, 2015. Her employment was terminated on January 20, 2017.
 - On February 16th, 2016, with the assistance of legal counsel, the OCC sent a self-disclosure overpayment letter to OMIG with calculations of Medicaid funds that needed to be returned or adjusted in our cost report. A letter seeking guidance regarding possible Medicare overpayments was also sent to National Government Services, Medicare’s Administrative Contractor. The letters requested guidance on the amount of overpayment and a possible reduction of 25 percent due to historic actual Medicaid reimbursement rates at NYC Health + Hospitals/Kings.
 - On September 26, 2016, OMIG denied the reduction request and provided a revised formula for calculating the amount due. A supplemental disclosure including a calculation of the overpayment amount, according to the revised Mixed Payer formula OMIG requested, was sent to OMIG on December 12, 2016. A reply from NGS, for guidance on a possible Medicare overpayment, has not yet been received.
- *OIG, SAM and OMIG Exclusions of Woodhull Hospital Nurse, Required Self-Disclosure and Voluntary Refunds*
- In December 2016, the Audit Committee was advised about a Woodhull Hospital Nurse who appeared on the OIG and SAM exclusion lists, effective October 20, 2016. Subsequently, she appeared on OMIG’s exclusion list, also effective October 20, 2016. On November 10, 2016, she was placed on unpaid administrative leave and was advised that she had 75 days to resolve the exclusion issue or she would be terminated. She resigned on November 29, 2016.
 - Pursuant to OMIG’s and OIG’s protocols, self-disclosure letters were sent to OMIG on January 5, 2017 and to OIG on January 10, 2017. A voluntary refund check for \$3,537.89 was mailed to OMIG on January 24, 2017. A check for a

voluntary Medicare refund of \$1,385.17 and a voluntary Tricare refund of \$4.71 was mailed to the National Government Services on January 26, 2017.

IV. Privacy Incidents and Related Reports

Background

1) The Office of HIPAA Privacy and Security within the OCC is responsible for reviewing, investigating, and responding to potential and confirmed breaches of Protected Health Information (“PHI”).

Reportable Privacy Incidents for the Fourth Quarter of Calendar Year 2016 (October 1, 2016 to December 31, 2016 – hereinafter “4th Quarter”)

2) During the period of October 1, 2016 to December 31, 2016, thirty-nine (39) complaints were entered in the ID Experts RADAR Incident Tracking System. Of the 39 complaints entered in the tracking system, ten (10) were found after investigation to be violations of the System’s HIPAA Privacy Operating Procedures; seven (7) were determined to be unsubstantiated; fourteen (14) were found not to be a violation of the System’s HIPAA Privacy Operating Procedures; and eight (8) are still under investigation.

- Of the 10 incidents confirmed as violations, 4 were determined to be breaches. A total of 5 individuals were affected by the 4 confirmed breaches.

Breach Defined

3) A breach is an impermissible use, access, acquisition or disclosure (hereinafter collectively referred to as “use and/or disclosure”) under the HIPAA Privacy Rule that compromises the security and privacy of PHI maintained by the Corporation or one of its business associates.⁹

4) Pursuant to 45 CFR § 164.402 [2], the unauthorized access, acquisition, use or disclosure of PHI is presumed to be a breach unless NYC Health + Hospitals can demonstrate that there is a low probability that the PHI has been compromised based on the reasonable results of a thorough risk assessment, that is completed in good faith, that involved the review of several key risk factors.¹⁰

Factors Considered when Determining Whether a Breach has Occurred

⁹ 45 CFR § 164.402 [“Breach” defined].

¹⁰ See 45 CFR § 164.402[2]; see also 78 Fed. Register 5565 at 5643 and 5695 [January 25, 2013]

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5) Under HIPAA regulations, at a minimum the following four key factors must be considered to determine whether there is greater than a low probability that a privacy and/or security incident involving PHI has resulted in the compromise of such PHI:¹¹

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed; and
- The extent to which the risk to the protected health information has been mitigated.

Reportable Breaches in the 4th Quarter

6) As stated above, there were 4 reportable breaches in the 4th Quarter. Below is a summary of said breaches:

- Elmhurst Hospital Center and Jacobi Medical Center – October 2016

Incident: The incident occurred when Cerner, a NYC Health + Hospitals business associate, encountered a printing issue when preparing billing statements to be sent to our patients. The error caused the last page of a patient's billing statement to be included with the billing statement sent to another patient. The error caused the PHI of two patients, one from Elmhurst and one from Jacobi, to be disclosed to a patient from another covered entity/business partner of Cerner. The PHI included patient name, statement date, guarantor account ID, charges, date of service, and description of service. Cerner notified NYC Health + Hospitals of the incident and corrected the error.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the two affected individuals on December 16, 2016.

Mitigation: To mitigate the error and to prevent such errors from happening in the future, Cerner updated their quality check process to include a manual record of the completion of a quality checklist by operators for any jobs that experience errors during printing. Cerner also retrained the operators by providing written reminders of the quality checkpoints at each operator station in addition to having the quality checkpoints posted in common areas.

¹¹ See 45 CFR § 164.402 [2][i-iv].

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- Metropolitan Hospital Center – November 2016

Incident: The incident involved a System employee disclosing the in-patient status of a patient, who was also a Metropolitan employee, to the patient’s coworkers. The patient was admitted to the psychiatric unit of Metropolitan. The employees/coworkers then attempted to visit the unit the patient was located without authorization. The employees were prevented from seeing the patient by nursing staff.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on December 23, 2016.

Mitigation: The employee who disclosed the patient’s information and the employees who attempted to visit the patient were retrained on HIPAA patient privacy rights as well as NYC Health + Hospitals policies regarding patient privacy.

The OCC is following up with the facilities Human Resources department to determine whether further discipline is being explored.

- Lincoln Medical and Mental Health Center – November 2016

Incident: The incident involved a patient receiving an appointment slip intended for another patient. The appointment slip contained PHI such as patient name, medical record number, clinic name, and appointment information. The patient presented to the Radiology clinic for the appointment when an employee noticed the error and collected the slip. The appointment slip was not returned to the incorrect patient. The mix-up occurred when both patients were seen in the Medicine Primary Clinic on the same day in August 2016.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification was sent to the affected individual on January 17, 2016.

Mitigation: The Medicine Primary Care clinic employees received retraining on the requirements to check for two forms of identification prior to releasing any confidential documents to our patients.

- Kings County Hospital Center – December 2016

Incident: The incident involved a social worker erroneously sending a fax, which included the discharge summary of one patient, to the workplace of a family member of another patient. The social worker also failed to include a fax cover sheet along with the documents that were faxed. Upon discovering that she had received the information of another patient,

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the recipient contacted the Patient/Guest Relations department at Kings to alert them of the error. The recipient then proceeded to destroy the fax and confirmed as such with Patient/Guest Relations. The discharge summary included PHI such as the patient's name, date of birth, medical record number, treatment information, medication, and diagnosis.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Notification will be sent to the affected individual no later than February 20, 2017.

Mitigation: The employee was required to attend HIPAA retraining led by the Facility Privacy Officer. The retraining included a review of HIPAA and PHI, accidental and unintentional disclosures, procedures for faxing confidential information, HIPAA OP 250-19 Transmission Security, HIPAA Do's and Don'ts, and tips on safeguarding patient privacy. The director of social work also requested that the FPO provide in-service to the entire department covering the same topics in the one-on-one training. Lastly, a new fax cover letter was developed which now includes a statement on re-disclosure at the bottom of the fax.

V. Compliance Reports for the Fourth Quarter of CY16 (October 1, 2016 to December 31, 2016) ("4th Quarter of CY16")

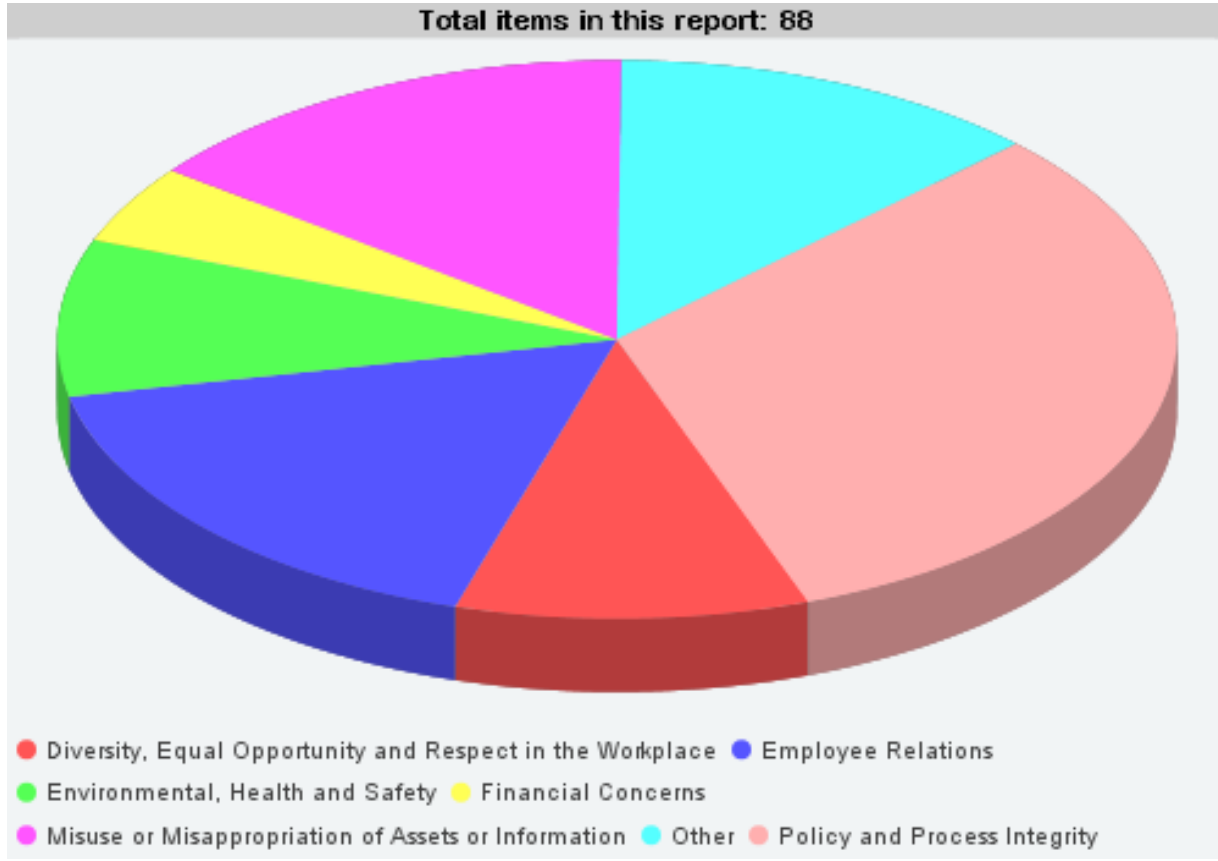
Summary of Reports

1) For the fourth quarter CY2016 (October 1, to December 31, 2016) there were 88 compliance-based reports of which 34 (38.6%) were classified as a Priority "B"¹² and 54 (61.4%) were classified as a Priority "C" reports. There were no Priority "A" reports. For purposes here, the term "reports" means compliance-based inquiries and compliance-based complaints. The breakdown of 4th quarter reports by subject, source and allegation are as follows:

Summary of Reports by Subject

2) The following is a summary of the reports by subject in the 4th Quarter of CY16:

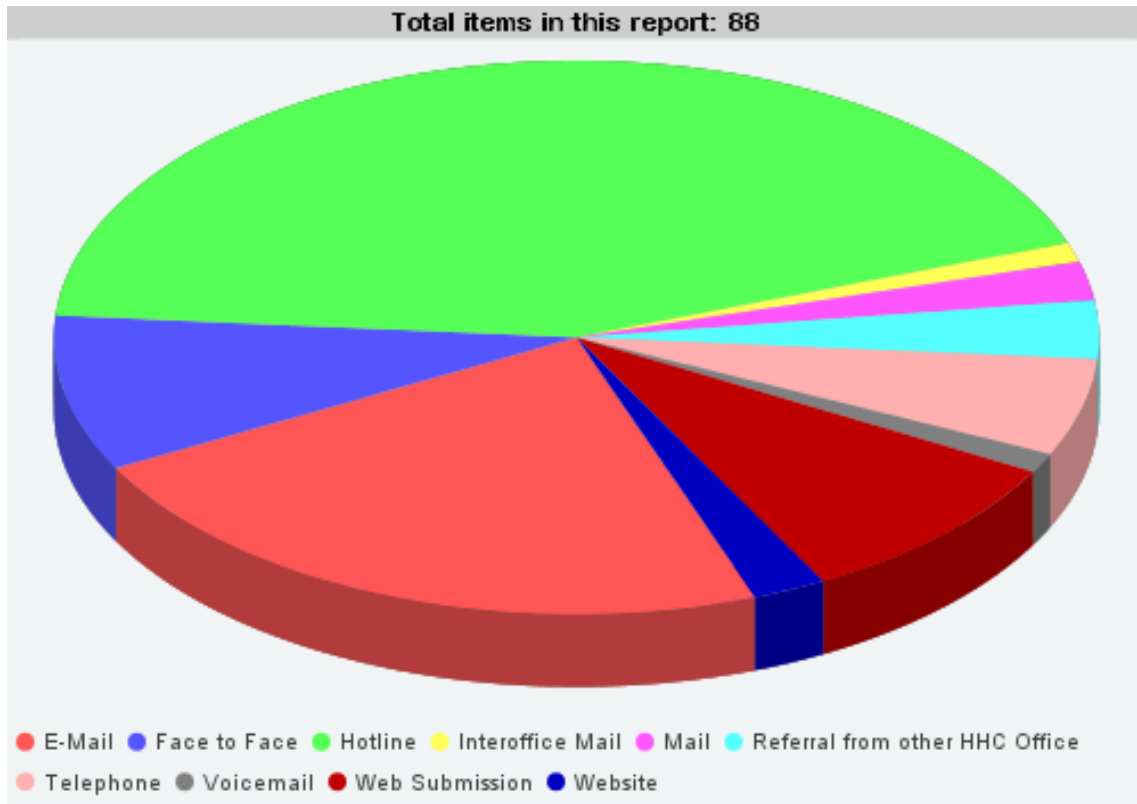
¹² There are three (3) different report categories: (i) Priority "A" reports - matters that require immediate review and/or action due to an allegation of immediate threat to a person, property or environment; (ii) Priority "B" reports – matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority "C" reports – matters that do not require immediate action.



Distribution of Reports by Subject

Diversity, Equal Opportunity and Respect in the Workplace	9.0 (10.2 %)
Employee Relations	15.0 (17 %)
Environmental, Health and Safety	8.0 (9.1 %)
Financial Concerns	4.0 (4.5 %)
Misuse or Misappropriation of Assets or Information	13.0 (14.8 %)
Other	11.0 (12.5 %)
Policy and Process Integrity	28.0 (31.8 %)
Totals	88.0 (100%)

3) The following is a summary of the reports by source in the 4th Quarter of CY16

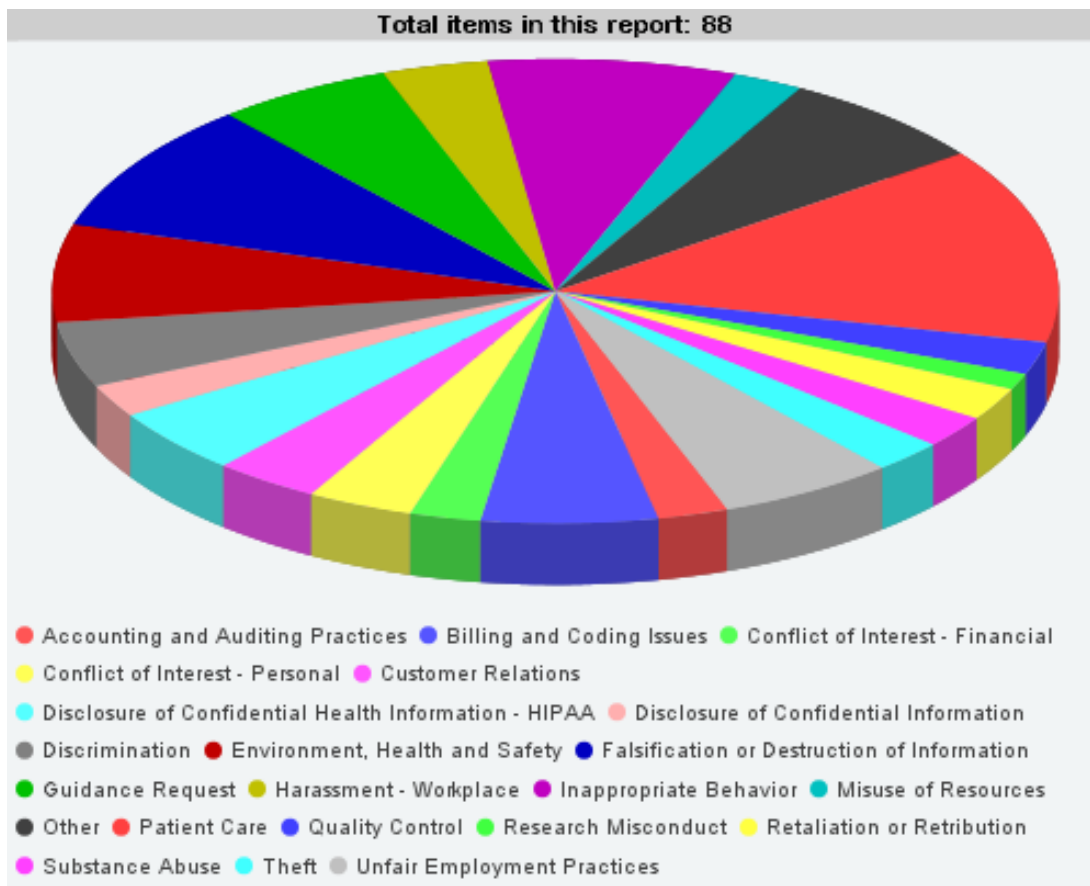


Distribution of Reports by Source

E-Mail	20.0 (22.7 %)
Face to Face	8.0 (9.1 %)
Hotline	38.0 (43.2 %)
Interoffice Mail	1.0 (1.1 %)
Mail	2.0 (2.3 %)
Referral from other HHC Office	3.0 (3.4 %)
Telephone	5.0 (5.7 %)
Voicemail	1.0 (1.1 %)
Web Submission	8.0 (9.1 %)
Website	2.0 (2.3 %)
Totals	88.0 (100%)

Reports by Allegation

4) The following is a summary of the reports by allegation in the 4th Quarter of CY16



Distribution of Reports by Allegation

Accounting and Auditing Practices	2.0 (2.3 %)
Billing and Coding Issues	5.0 (5.7 %)
Conflict of Interest - Financial	2.0 (2.3 %)
Conflict of Interest - Personal	3.0 (3.4 %)
Customer Relations	3.0 (3.4 %)
Disclosure of Confidential Health Information - HIPAA	4.0 (4.5 %)
Disclosure of Confidential Information	2.0 (2.3 %)

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Discrimination	4.0 (4.5 %)
Environment, Health and Safety	6.0 (6.8 %)
Falsification or Destruction of Information	8.0 (9.1 %)
Guidance Request	5.0 (5.7 %)
Harassment - Workplace	3.0 (3.4 %)
Inappropriate Behavior	7.0 (8 %)
Misuse of Resources	2.0 (2.3 %)
Other	6.0 (6.8 %)
Patient Care	12.0 (13.6 %)
Quality Control	2.0 (2.3 %)
Research Misconduct	1.0 (1.1 %)
Retaliation or Retribution	2.0 (2.3 %)
Substance Abuse	2.0 (2.3 %)
Theft	2.0 (2.3 %)
Unfair Employment Practices	5.0 (5.7 %)
Totals	88.0 (100%)

VI. OneCity Health/DSRIP Compliance Update – DSRIP Compliance Training and Education and Assessment of the Compliance Integrity of OneCity Health Partners

OCC Memorandum dated December 30, 2016 and DSRIP Compliance Training Materials

1) On December 30 2016, the NYC Health + Hospitals’ Office of Corporate Compliance (“OCC”), sent a Memorandum to all performing providers (hereinafter also referred to as “Partners”) in the NYC Health + Hospitals-sponsored OneCity Health Services (“NYC Health + Hospitals/OneCity Health” or “OneCity Health”) Performing Provider System (“PPS”) reminding them of their Delivery System Reform Incentive Payment (“DSRIP”) program compliance training and education requirements. The Memorandum addressed the following topics:

- DSRIP compliance training and education requirements under New York State (the “State”) law and New York State Office of the Medicaid Inspector General (“OMIG”) DSRIP compliance guidance;
- Training and education materials related to the Deficit Reduction Act (“DRA”) of 2005 previously disseminated to OneCity participants in September 2016; and
- An overview of a PowerPoint presentation, *Delivery System Reform Incentive Payment Program Compliance Training and Education*, which the Partners were told could be utilized to meet their DSRIP compliance training obligations.

OneCity Health DSRIP Compliance Training and Education PowerPoint Presentation

2) To assist the OneCity Health Partners to meet their DSRIP compliance training requirement, the OCC attached to the December 30, 2016 Memorandum a *Delivery System Incentive Payment Program Compliance Training and Education PowerPoint* presentation prepared by OneCity Health for DSRIP compliance training and education purposes. Partners were instructed that they were welcomed to utilize the presentation to satisfy their DSRIP compliance training and education requirements.

Overview of the Content of the DSRIP Compliance Training PowerPoint

- 3) The PowerPoint covered the following core topics:
- What is DSRIP and who are the key players?
 - What is NYC Health + Hospitals/OneCity Health Performing Provider System?
 - Why is the establishment of compliance program beneficial?
 - What are the legally required elements of a compliance program?
 - With regard to the required compliance program elements, what are the special considerations for DSRIP compliance?
 - What are the definitions of the terms Fraud, Waste and Abuse and corresponding examples of the same?
 - What are some of the Federal laws covering Fraud, Waste and Abuse that OneCity Health participants should be familiar with?
 - How can OneCity Health participants report a DSRIP-related compliance issue or concern?

Background and Legal Requirements Regarding DSRIP Compliance Training

4) Pursuant to State mandatory provider compliance program regulations, NYC Health + Hospitals is required to adopt and implement an effective compliance program, which includes the provision of periodic compliance “training and education of all affected employees and persons associated with NYC Health + Hospitals . . . on compliance issues and expectations of the compliance program.”¹³ Under OMIG compliance guidance, these compliance training and

¹³ 18 NYCRR §521.2[c][3]; *see also* 18 NYCRR § 521.1; Social Services Law § 363-d [2][c]

education requirements extend to the DSRIP program. More particularly, OneCity Health as a PPS lead, is responsible for taking “reasonable steps to ensure that [M]edicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse”¹⁴, and compliance training and education is a key component in meeting this requirement. Accordingly, all OneCity partners who have received or are eligible to receive DSRIP funds are required to undergo compliance training and education on the NYC Health + Hospitals/OneCity Health compliance program.¹⁵ OneCity Health Partners were instructed that they could satisfy their compliance and training obligations by utilizing the compliance materials attached to the Memorandum.

Previous Training and Education Disseminated to OneCity Health Partners

5) In September 2016, the OCC provided all OneCity Health Partners with a memorandum concerning the Deficit Reduction Act of 2005, wherein recipients were informed of: (i) NYC Health + Hospitals internal policies covering the prevention and detection of fraud, waste, and abuse; (ii) the Federal False Claims Act and any similar law under the State that governs false claims and statements; and (iii) whistleblower protections under Federal and State laws. As part of meeting compliance training requirements, OneCity Health Partners were instructed that they should, if they had not already done so, disseminate the DRA memorandum to its workforce members that are involved with, or otherwise affected by, the DSRIP program.

Use of the DSRIP Training by OneCity Health Partners

6) The Partners were instructed that the PowerPoint could be utilized in one or more of the following three ways:

- The development of a presentation for in-person/live compliance and education training;
- The incorporation of the content of the PowerPoint in the existing Partners’ compliance training and education computerized or otherwise automated training models; or
- The distribution of the PowerPoint to their workforce members involved with or otherwise affected by the DSRIP program.

OneCity Health Compliance Webinar with Partners on January 10, 2017

¹⁴ Office of the Medicaid Inspector General Delivery System Reform Incentive Payment (“DSRIP”) Program DSRIP Compliance Guidance 2015-01 –revised – Special Considerations for Performing Provider System (“PPS”) Leads’ Compliance Program available at:

https://www.omig.ny.gov/images/stories/compliance_alerts/20150901_DSRIP_CompGuidance_2015-01_Rev.pdf

¹⁵ See *id.*

7) OneCity Health also held a Partner webinar on January 10, 2017, which included, among other important topics, a presentation on DSRIP compliance training requirements. During the webinar, Partners were provided with further information on DSRIP compliance training requirements. The Partners were also informed that the DSRIP compliance training materials were posted on the OneCity Health website.

Compliance Attestation of OneCity Health Partners

Background

8) The December 30, 2016 Memorandum from the OCC informed the Partners that in early 2017, OneCity Health would email all OneCity Health Partners with instructions on how to certify that they have met the DSRIP compliance and education training requirements as described herein as well as other compliance-related matters.

9) On February 2, 2017, all OneCity Health Partners were provided with a Memorandum from the OCC, which included as an attachment a *Compliance Attestation of OneCity Health Partners* (“Attestation”). The Attestation, which on a whole provides OneCity Health with a critical snapshot of the compliance foundation of its Partners, must be completed by all Partners and returned to the NYC Health + Hospitals/OneCity Health Office of Corporate Compliance (“OCC”) by close of business on March 20, 2017.

10) The February 2, 2017 OCC Memorandum covered the following topics:

- Why the Attestation is required;
- The key topics covered in the Attestation; and
- The next steps Partners are required to take with regard to completing and submitting the Attestation to the NYC Health + Hospitals/OneCity Health OCC.

Overview of the Key Components of the OneCity Health Partner Compliance Attestation

11) The February 2, 2017 OCC Memorandum addressed the following key Attestation topics, respectively;

- The status of completion of DSRIP compliance training by their medical practice or organization (hereinafter collectively referred to as “Organization”);
- An acknowledgment by Partners that their workforce members are familiar with and adhere to the *NYC Health + Hospitals Principles of Professional Conduct*;

and

- Proof of OMIG compliance program-related certifications by those Partners that are required by law and/or OMIG policy to submit such certifications.

Partner Completion of Required Compliance Training

12) In the Attestation the Partners are asked to confirm they have completed the compliance training requirement and the method by which the training was delivered.

NYC Health + Hospitals Principles of Professional Conduct

13) The NYC Health + Hospitals Principles of Professional Conduct (“POPC”), which is a guide that sets forth NYC Health + Hospitals’ compliance expectations and describes NYC Health + Hospitals’ standards of professional conduct as well as efforts to prevent, fraud, waste, and abuse.

14) All Partners must adhere to the requirements outlined in the POPC. In sum and substance, the POPC calls for Partners to meet the following key requirements:

- Adopt the POPC or their own code of conduct that includes the POPC’s core objectives or substantially similar compliance goals;
- Refrain from engaging in unprofessional conduct, as described in Section VI of the POPC, which includes, for example, the following:
 - The misuse or misallocation of DSRIP funds; and
 - The hiring or contracting with persons or entities excluded from participation in Federal health care programs;
- Timely report to NYC Health + Hospitals any violation of the POPC of which it becomes aware; and
- Fully cooperate, to the extent applicable, with any investigation by NYC Health + Hospitals or, if required, any governmental agency.

15) In the Attestation, Partners are asked a series of questions to confirm whether or not they have met the foregoing requirements of the POPC.

OMIG Annual Compliance Certifications

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16) NYC Health + Hospitals/OneCity Health's OCC utilizes the following two OMIG compliance certifications to help it assess the program integrity of Partner's compliance foundation:

- The New York Social Services Law § 363-d Certification; and
- The Deficit Reduction Act of 2005 Certification.

To this end, The Attestation asks a series of questions to determine whether a Partner is required to submit to OMIG one or both of the two aforementioned certifications, and if so, whether said Partner has actually carried out this requirement.

New York Social Services Law § 363-d and 18 NYCRR Part 521

17) New York Social Services Law ("SSL") § 363-d and its implementing regulations found at 18 NYCRR Part 521, require certain providers to annually certify through the OMIG website that they have an "effective" compliance program. Certifications are required by provider organizations that:

- Are subject to Public Health Law Articles 28 or 36¹⁶;
- Are subject to Mental Hygiene Law Articles 16 or 31¹⁷; or
- Claim, order, bill or receive at least \$500,000 within a 12 month period from Medicaid¹⁸.

18) The Attestation requires Partners who confirmed that they completed the SSL 363-d certification to include proof of the same (e.g., a copy of the electronic confirmation receipt that OMIG provided to each Partner upon their SSL 363-d certification submission) along with their completed Attestation.

Deficit Reduction Act of 2005

19) The Deficit Reduction Act of 2005 ("DRA") requires providers who receive or make \$5 million or more in direct Medicaid payments to annually certify through the OMIG website that they have:¹⁹

¹⁶ 18 NYCRR 521.1[a]

¹⁷ See *id.* at § 521.1 [b]

¹⁸ See *id.* at § 521.1 [c]; see also *id.* at 521.2 [b]

¹⁹ See OMIG *DRA Certification Revised* (12/01/2016) [DRA Questions], available at: <https://www.omig.ny.gov/dra-certification>.

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- Established and disseminated to all their employees, including management, and any contractor or agent of their provider organization, written policies that provide detailed information about²⁰:
 - The Federal False Claims Act, remedies for false claims and statements, and State laws pertaining to civil or criminal penalties for false claims and statements;
 - Whistleblower protections under the Federal False Claims Act and State laws;
 - The role of the Federal False Claims Act and State law in preventing and detecting fraud, waste, and abuse in Federal health care programs; and
 - The provider organization's policies and procedures for detecting fraud, waste, and abuse; and
Included the following information in the providers organization's employee handbook (if one exists):
 - Information about the Federal False Claims Act and comparable New York State laws;
 - A specific discussion of the rights of provider organization's employees to be protected as whistleblowers; and
 - A specific discussion of the provider organization's policies and procedures for detecting fraud, waste and abuse.

20) The Attestation requires Partners who confirmed that they completed the DRA certification to include proof of the same (*e.g.*, a copy of the electronic confirmation receipt that OMIG provided to each Partner upon their DRA certification submission) along with their completed Attestation.

OneCity Health Webinar with Partners Scheduled for February 14, 2017

21) A OneCity Health webinar with Partners is scheduled for February 14, 2017. The OCC will participate in one portion of the webinar to answer any questions that Partners may have concerning the Compliance Attestation.

²⁰ See summary questions related to the requirements of the DRA derived from 42 USC §1396a (a)(68); *see also* OMIG's *NYS Mandatory Provider Compliance Program Certification - DRA Certification Form* [DRA Questions], available at: <https://www.omig.ny.gov/certification-header?type=dra>